South Dakota Family Planning
Department of Health

Chart Number _____

SOUTH DAKOTA DEPARTMENT OF HEALTH
HEALTH AND MEDICAL SERVICES
FAMILY PLANNING PROGRAM

CONSENT FOR INTRAUTERINE DEVICE (IUD) REMOVAL

Client Name _____

I request and consent to have my IUD removed. I have been advised that there may be some discomfort, uterine bleeding, and/or other problems associated with the removal of the IUD. I acknowledge that I have received all information provided by and requested from the agency/clinic regarding this procedure.

I have been further advised that IF I am pregnant at the time of the removal there is, in addition to the above, a chance of approximately 25% that the removal of my IUD might cause a miscarriage. The chance of a miscarriage if my IUD is left in is approximately 50%. In addition, other problems could arise such as infections.

I have been advised that I will be provided with answers to any and all inquiries regarding this procedure should I have a concern. I understand it is my responsibility to inform this agency/clinic of any difficulties and return to this agency/clinic for regularly scheduled visits as requested of me.

I release the South Dakota Department of Health, South Dakota Family Planning Program and its employees or agents from any and all claims, damages, or liabilities which I may have against them as a result of the receipt of medical services, supplies, and/or procedures.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date